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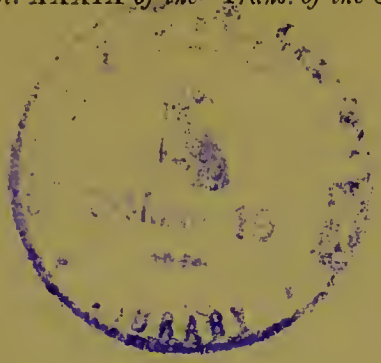

FIBROMA OF THE OVARY; IMPACTION; ASCITES; REMOVAL.

Shown by Mr. Alban Doran.

S. B—, aged 49, married twenty-three years, eleven children, last confinement eleven years ago, consulted Dr. Chill in January, 1896, and he detected a tumour in the hypogastrium. On January 31st he sent the patient to me, and I made out an extremely hard mass which rose just above the pelvis; it was almost fixed. The sound passed 3½ inches forwards, and the uterus was fixed. I pressed on the tumour, and it at length moved up.

I diagnosed "impacted fibroid," which was correct to a certain extent, but the tumour proved to be ovarian, not uterine as I suspected at the time.

The tumour grew slowly till last autumn, then the patient found that the abdomen increased rapidly in size. She was admitted into the Samaritan Hospital on December 31st, 1896. I saw at once that the distension of the abdomen was due to ascites. The circumference at the umbilicus was 46 inches, though the patient was not a big woman. The parietes were œdematous, the subcutaneous veins moderately dilated. The hard tumour, which reached to within an inch of the umbilicus, floated about, or rather, when it was pushed a kind of ballottement could be felt. The uterine cervix lay far back; both fornices were quite free. The sound passed nearly 4 inches. I now found that the uterus seemed to rotate almost independently of the tumour. I began to suspect

that the fibroma was ovarian, chiefly on account of the partial independence of the tumour from the uterus, and the presence of dropsy. There was no evidence of visceral disease. The catamenia had ceased for nearly two years.

On January 12th, 1897, assisted by Mr. Targett, I removed the tumour. The pedicle was extremely short, and over 5 inches broad. It had, so to speak, three planes: a broad layer of peritoneum, forming a special ovarian mesentery, standing back from the mesosalpinx (this condition is not rare in very short pedicles); secondly, the mesosalpinx, much elongated; and lastly, the ovarian ligament, 3 inches long; it had formed for itself a deep fold.

I secured the ovarian vessels, which lay on the outer edge of the first plane, with No. 2 silk, then I transfixed the inner half of the pedicle with No. 4 silk well below the mesosalpinx, and tied it firmly, including the left uterine cornu. The tense pedicle was unavoidably split during these manipulations. I tied the outer half separately with No. 4 silk, including the groove made by the ligature on the ovarian vessels. This method, after Penrose,* is preferable to interlacing ligatures, which in very broad pedicles often involves more splitting. The tumour was now cut away; it weighed 4 lbs. 7 oz. Two large arteries on the cut surface of the inner pedicle spouted till I drew the ligatures very firmly. As an extra precaution I fixed dressing-forceps on their gaping mouths, and left those instruments in place till all the sutures had been applied. Then the wound was closed.

The patient did well from the first, and has now practically recovered. Mr. Targett examined the tumour, and found that it was a pure fibroma, with a cavity in the centre from breaking down of tissue.

Had it not been for the shortness of the pedicle, which bore big vessels externally and internally, the operation would have been easy. The process of ligature, with the

* "The Ligature in Oöphorectomy," 'Amer. Journ. Obstetrics,' vol. xxxii, 1895, pp. 221 and 290.

solid uncollapsible tumour in the way, was difficult, even though I cut through the outer border directly the ovarian vessels were secured. There were no adhesions.

This case, of which I was thinking when I spoke on Dr. Hubert Roberts's specimen exhibited last month, just before I operated, illustrates the fact that ascites is quite frequent in ovarian fibroma, whilst in uterine myoma, also a hard and heavy tumour, it is decidedly rare, even when the myoma is pedunculated. In this case the ascites was unusually marked, I feared papilloma or malignancy. As usual, the patient suffered little pain.

Just before the operation the uterine cavity measured 4 inches. This was due to the extreme shortness and breadth of the pedicle and the shape of the solid tumour, which lay with its transverse and longest diameter (over 8 inches) across the pelvic brim. Thus the body of the uterus was exposed to constant and increasing traction. Let it be remembered that the uterus only measured $3\frac{1}{2}$ inches a year before operation, when the tumour was impacted, for under that condition it was not dragged upon, nor was the tumour and its pedicle so developed as at the time of the operation. In Case 11 in my communication on "Fibroma of the Ovary and Ovarian Ligament," the patient was a virgin aged twenty-four, and the uterus measured $3\frac{1}{4}$ inches. This elongation I found to be due to twisting of the pedicle. The solidity of a fibroma makes it a good fixed point for traction. I dwell on this question, the increase of length of the uterus, as it is liable to make the observer believe that the ovarian tumour is uterine, and such an error of diagnosis, not so excusable in the case of the girl of twenty-four, is very natural in the present instance, where the patient was forty-nine.

Impaction of an ovarian tumour with a true pedicle is certainly rare.

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